DIOCESE OF VENICE IN FLORIDA

Department of Education

STUDENT/PARTICIPANT SELF-SCREENING FORM

Parent Name: _____

Student/Participant Name: _____

Date: _____ Parent Mobile Number: _____

School Name: _____

1. Is your student/participant showing any signs of the following symptoms?

- ❑ Temperature 100.4 or higher
- ❑ Shortness of breath, difficulty breathing
- ❑ Cough
- ❑ Runny nose
- ❑ Sneezing
- ❑ Muscle Pain
- ❑ Tiredness

2. Has the student/participant been exposed to someone with COVID-19 positive test results?

- ❑ YES
- ❑ NO

3. Is the information you provided on this form true and correct to the best of your knowledge?

- ❑ YES
- ❑ NO

Parent Signature: _____

NOTES: Participation is forbidden if the student-athlete displays any of the symptoms mentioned in question 1 or a YES response to question 2. If either applies, participants will be directed to leave the premises. Disinfecting the visited area will need to take place immediately.